Abbey Field Medical Centre

Quality Report

Abbey Field Medical Centre,
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Abbey Field Medical Centre is a location base operated by One to One (North West) Limited in Essex. The service provides community midwifery services to women and their babies in the North East Essex region

We carried out announced inspections on 19 January and 06 February 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. We have not rated the service because we do not have sufficient evidence to rate the service of this type at this time.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

- Training records showed only 33% of maternity assistants (MAMAs) were compliant with their mandatory training requirements.
- There were no audits carried out to check the cleanliness of the environment or hand hygiene.
- A birthing pool audit had been carried out; however, this did not cover visual inspection of the pools or whether midwives were cleaning the pool correctly.
- No record of cleaning was maintained for the medicines fridge nor the fridge used to store placentas.
- Midwives were not transporting Entonox (Nitrous Oxide) securely in their cars during transport. This was not compliant with national safety recommendations.
- There was no system in place to track what visits each member of staff had planned for each day. Our concerns were heightened given there was no local manager in post. This meant there was no record of where lone workers were at any time, and no one had oversight of staff whereabouts.
- The provider was not registered to supply and administer controlled medicines (such as pethidine), however, two midwives told us that they administered and disposed of Pethidine for homebirth women, because the local GP prescribes the medicine for the women as required. There was no record of Pethidine waste kept. Whilst senior managers told us that this practice was not in line with the provider's protocol, the 'Medicine's management' policy in place however did not make this clear. The provider informed us that this practice would be stopped immediately.
- Midwives were inconsistent in the medicines they offered women for the management of the third stage of labour. We also found the provider's "Management of the third stage of labour" policy did not reflect evidence-based practice in relation to these medicines.
- Women and babies electronic and paper healthcare records did not reflect one another, often containing conflicting information in terms or pregnancy risk.
- Although women were on the correct pathway for their pregnancy in correlation with risk, we saw that the pathway title, such as low or high risk, where often missing or incorrect from their records.
- Of the healthcare records we checked, we saw that there was no paper record of postnatal care for women and babies. However, the provider had recently introduced new paperwork to ensure this. Although because this system was new we were unable to check if these paper postnatal records were being completed.
- Maternal Early Obstetric Warning (MEOWS) charts were not in use and scores were not calculated.
- Where care had deviated from evidence-based practice recommendations, such as if a vaginal examination was not performed in labour, we saw that the reasons for this were not recorded in women's healthcare records.
- Staff did not have regular one-to-one meetings with a manager.
- Staff did not demonstrate they understood the Fraser guidelines sufficiently.
- Midwives had not received additional training in complex conditions in pregnancy, such as diabetes.

Summary of findings

- Of the twelve midwives employed in the Essex area, seven midwives were newly qualified or had been qualified for approximately a year. There was also no clinical manager for the area. This meant that the majority of staff were junior without adequate local supervision in terms of management.
- The service had not carried out a needs assessment of the local community it provided a service to.
- There had not been a registered manager in post since July 2015. There had also been no clinical manager based at the Essex service since November 2016 since the previous manager resigned from their post. This meant that 12 midwives, three midwifery support assistants (MAMAs) and an operations manager worked without clinical management presence. Staff told us that there was one clinical manager in the North West location; who line managed them and was accessible via telephone as required. However two senior managers also confirmed that this clinical manager only visited the Essex service bi-monthly.
- The provider's risk register did not mention who was accountable for each presented risk, and correlating action plans to the risk register were not updated following risk register review.

We also found areas of good practice.

- The provider had made significant improvements since our last inspection in February 2016. This included improvements to incident reporting, risk assessments, policies and procedures and safeguarding.
- All new starters received a six week induction training programme and a preceptorship programme was also in place for midwives. Competency framework were also in used.
- Hypnobirthing and water (birthing pool) services were available to women for pain relief in labour.
- Breastfeeding rates were good. 86.5% of women who delivered breastfed their babies within 48 hours of birth and 51.4% of women were still breastfeeding their babies at 10-14 days postnatal.These rates were above the national average.
- There were arrangements to review guidance from national bodies such as the National Institute for Health and Care Excellence (NICE).
- Two midwives were trained to carry out the examination of the newborn check (NIPE) required with 48 hours of delivery.
- Staff had access to an abundance of up-to-date policies and procedures electronically via their work tablet device.
- The Supervisor to Midwife (SoM) to midwife ratio was 1:12, which was better than the current Nursing Midwifery Council (2012) guidelines.
- Staffing levels for midwife to women ratio were safe.
- Women, babies and their families were treated with dignity and respect, and staff were offered appropriate emotional support tailored to individual need.
- Feedback from people who used the service was consistently good.
- There were no waiting lists for people accessing the service or for appointments. Antenatal and postnatal contacts were flexible in terms of amount and length, and appointments were offered at a convenient time and location to the women.
- All staff we spoke with knew the provider's vision and set of values.
- There was a clear governance process in place including a risk register, monthly "Quality Assurance Groups" and a clinical dashboard, which was well monitored.
- Staff spoke highly of their seniors within the organisation, saying they were encouraging, supportive and friendly.

Following this inspection, we told the provider that it must take some actions to comply with the regulations to help the service improve. Details are at the end of the report.

Professor Edward Baker
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Maternity		• Training records showed only 33% of maternity assistants (MAMAs) were compliant with their mandatory training requirements. • There were no audits carried out to check the cleanliness of the environment or hand hygiene. • A birthing pool audit had been carried out; however, this did not cover visual inspection of the pools or whether midwives were cleaning the pools correctly. • No record of cleaning was maintained for the medicines fridge nor the fridge used to store placentas. • Midwives were not transporting Entonox (Nitrous Oxide) securely in their cars during transport. This was not compliant with national safety recommendations. • There was no system in place to track what visits each member of staff had planned for the day. Our concerns were heightened given there was no local manager in post. This meant there was no record of where lone workers were at any time, and no one had oversight of staff whereabouts. • The provider was not registered to supply and administer controlled medicines (such as pethidine), however, two midwives told us that they administered and disposed of Pethidine for homebirth women, because the local GP prescribes the medicine for the women as required. There was no record of Pethidine waste kept. Whilst senior managers told us that this practice was not in line with the provider's protocol, we however saw that the 'Medicine's management' policy in place did not make this clear. • Midwives were inconsistent in the medicines they offered women for the management of the third stage of labour. We also found the provider's "Management of the third stage of labour" policy did not reflect evidence-based practice in relation to these medicines.

Summary of findings

- Women and babies electronic and paper healthcare records did not reflect one another, often containing conflicting information in terms or pregnancy risk.
- Although women were on the correct pathway for their pregnancy in correlation with risk, we saw that the pathway title, such as low or high risk, where often missing or incorrect from their records.
- Of the healthcare records we checked, we saw that there was no paper record of postnatal care for women and babies. However, the provider had recently introduced new paperwork to ensure this. Although because this system was new we were unable to check if these paper postnatal records were being completed.
- Maternal Early Obstetric Warning (MEOWS) charts were not in use and scores were not calculated.
- Where care had deviated from evidence-based practice recommendations, such as if a vaginal examination was not performed in labour, we saw that the reasons for this were not recorded in women's healthcare records.
- Staff did not have regular one-to-one meetings with a manager.
- Staff did not demonstrate they understood the Fraser guidelines sufficiently.
- Midwives had not received additional training in complex conditions in pregnancy, such as diabetes.
- Of the twelve midwives employed in the Essex area, seven midwives were newly qualified or had been qualified for approximately a year. There was also no clinical manager for the area. This meant that the majority of staff were junior without adequate local supervision in terms of management.
- The service had not carried out a needs assessment of the local community it provided a service to.
- There had not been a registered manager in post since July 2015. There had also been no clinical manager based at the Essex service since November 2016 since the previous manager resigned from their post. This meant that 12 midwives, three midwifery support assistants (MAMAs) and an operations manager worked without clinical management presence. Staff told us that there was one clinical manager in the North West location;

Summary of findings

who line managed them and was accessible via telephone as required. However two senior managers also confirmed that this clinical manager only visited the Essex service bi-monthly.

- The provider's risk register did not mention who was accountable for each presented risk, and correlating action plans to the risk register were not updated following risk register review.

Summary of findings

Contents

Abbey Field Medical Centre

Services we looked at
Maternity

Summary of this inspection

Background to Abbey Field Medical Centre

Abbey Field Medical Centre is located in Essex and operated by One to One (North West) Limited. The location is the main base for midwives who work in the community.

One to One (North West) Limited registered with CQC in May 2010 and provides a community based case loading midwifery led service with an ethos based on the concept of continuity of care. One to One is an independent provider of maternity services commissioned by the NHS. Services available include the provision of antenatal and postnatal care in the community setting as well as offering private scanning, homebirths and pool births.

One to One (North West) Limited operate predominantly from the North West of England; and expanded their service to cover part of Essex in 2015.

The Essex location operates from the Abbey Field Medical Centre and provides a service to women and their babies in the North East of Essex covering Clacton, Colchester and the surrounding areas. In this area, One to One (North West) Limited employs 12 midwives, three maternity assistants (MAMAs) and one operations manager.

There has not been a registered manager in post in Essex since July 2015.

Services are largely delivered from women's homes; however, there is flexibility in location, and the service aims for the women's named midwife to attend all the women's antenatal and post natal appointments, including ultrasound scans.

We last inspected this service in February 2016 following concerns raised to CQC by other organisations, including the local Clinical Commissioning Groups (CCGs). We set two requirement notices following the inspection and told the provider they must take action.

Our inspection team

The team that inspected the Essex service comprised of two inspection managers, a lead inspector with a background in midwifery, and another inspector who is a registered midwife. The inspection team was overseen by Fiona Allinson Head of Hospital Inspection.

We inspected this location at a similar time to the provider's other location (in the North West of England), and to ensure continuity of CQC staff, three members of the inspection team mentioned above were present at both inspections.

Information about Abbey Field Medical Centre

The Abbey Field Medical Centre is the only base for staff in the Essex location, and consists of one store room/office and outside Entonox (Nitrous Oxide) storage facilities; there was also access to meeting rooms as required and one computer desk. This location is registered to provide the following regulated activities:

- Maternity and midwifery services
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures

During the inspection, we visited the Abbeyfield Medical Centre location and checked the store room/office and the outside gas storage area. We spoke with 15 members of staff including; midwives, a maternity support worker, an operations manager, the safeguarding team, an obstetrician, and senior managers. We spoke with four women who had used the service, and read recent patient feedback, which the provider had collected. We also carried out data analysis of documents the provider sent us and reviewed 12 sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected one time before this inspection, and the most recent inspection took place in February 2016.

Summary of this inspection

Activity (April 2016 to December 2016)

- 204 women had booked their maternity care with One to One midwives, of which 39.9% were planned homebirths.

The service employed 12 midwives, three maternity support assistants and one operations manager; supported by further staff including the safeguarding team and clinical lead, which were based at the provider's headquarters in Birkenhead (North West of England). The service also employed an obstetrician who worked across the organisation, and on average provided obstetric antenatal care every six weeks in the Essex area, for women booked under the care of One to One Midwives and as required. There was no accountable officer for controlled drugs (CDs) as one was not required.

Track record on safety (December 2015 to December 2016):

- No Never events
- 112 clinical incidents
- One serious incident
- No serious injuries
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) nor E-Coli
- One complaint

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Maintenance of medical equipment
- Pathology and histology
- Supply of medical gases
- Provision of pool for homebirths

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We have not rated the safe domain. We found:

- Only 33% of maternity assistants (MAMAs) were compliant with all their mandatory training requirements.
- There were no audits carried out to check the cleanliness of the environment or hand hygiene.
- A birthing pool audit had been carried out; however, this did not cover visual inspection of the pools nor whether midwives were cleaning the pools correctly.
- No record of cleaning was maintained for the medicines fridge nor the fridge used to store placentas.
- Midwives were not transporting Entonox (Nitrous Oxide) securely in their cars during transport. This was not compliant with national safety recommendations.
- There was no system in place to track what visits each member of staff had planned for the day. Our concerns were heightened given there was no local manager in post. This meant there was no record of where lone workers were at any time, and no one had oversight of staff whereabouts.
- The provider was not registered to supply and administer controlled medicines (such as pethidine), however, two midwives told us that they administered and disposed of Pethidine for homebirth women, because the local GP prescribes the medicine for the women as required. There was no record of Pethidine waste kept. Whilst senior managers told us that this practice was not in line with the provider's protocol, we however saw that the 'Medicine's management' policy in place did not make this clear.
- Midwives were inconsistent in the medicines they offered women for the management of the third stage of labour. We also found the provider's "Management of the third stage of labour" policy did not reflect evidence-based practice in relation to these medicines.
- Women and babies electronic and paper healthcare records did not reflect one another, often containing conflicting information in terms or pregnancy risk.
- Although women were on the correct pathway for their pregnancy in correlation with risk, we saw that the pathway title, such as low or high risk, where often missing or incorrect from their records.
- Of the healthcare records we checked, we saw that there was no paper record of postnatal care for women and babies.

Summary of this inspection

However, the provider had recently introduced new paperwork to ensure this. Although because this system was new we were unable to check if these paper postnatal records were being completed.
- Maternal Early Obstetric Warning (MEOWS) charts were not in use and scores were not calculated.

However we also found:

- There was an incident report process in place, and learning from incidents occurred.
- Sufficient safeguarding processes existed, and staff acted appropriately to safeguarding women, babies and their families, whilst supporting them.
- Risk management systems and processes had been implemented to ensure the safeguarding team and clinical lead had oversight of the risk present in relation to midwives caseloads.
- Staffing levels were very good and appropriate for the service.

Are services effective?

We have not rated the effective domain. We found:

- Evidence based practice, such as undertaking a vaginal examination was not always performed in labour, we saw that the reasons for this were not recorded in women's healthcare records.
- Staff did not have regular one-to-one meetings with a manager.
- Staff did not have sufficient knowledge of Fraser guidelines.
- Of the twelve midwives employed in the Essex area, seven midwives were newly qualified or had been qualified for approximately a year. There was also no clinical manager for the area. This meant that the majority of staff were junior without adequate local supervision in terms of management.

However we also found:

- There was an annual audit programme in place.
- All new starters received a six week induction training programme and a preceptorship programme was in place for midwives. Competency framework was also in place.
- Hypnobirthing and water (birthing pool) services were available to women for pain relief in labour.
- Breastfeeding rates were good. 86.5% of women delivered breastfed their babies within 48 hours of birth and 51.4% of women were still breastfeeding their babies at 10-14 days postnatal. These rates were above the national average.

Summary of this inspection

- We found there were arrangements to review guidance from national bodies such as the National Institute for Health and Care Excellence (NICE) and that care was delivered in line with best practice.
- Two midwives were trained to carry out the examination of the newborn check (NIPE) required with 48 hours of delivery.
- The provider worked hard to develop and build good relationships with third party providers.
- Staff had access to an abundance of up-to-date policies and procedures electronically via their work electronic tablet device.
- The Supervisor to Midwife (SoM) to midwife ratio was 1:12, which was better than the current Nursing Midwifery Council (2012) guidelines.

Are services caring?

We have not rated the caring domain. We found:

- Women, babies and their families were treated with dignity and respect.
- Staff were offered appropriate emotional support tailored to individual need to people who used the service.
- We spoke with four women who had used the service, and reviewed patient feedback which showed caring was excellent.
- Friends and Family Test (FFT) results consistently showed that people who used the service would recommend One to One midwives to others.
- Additional surveys also showed consistently good feedback from people who used the service.

Are services responsive?

We have not rated the responsive domain. We found:

- There were no waiting lists for people accessing the service or for appointments.
- Antenatal and postnatal contacts were flexible in terms of amount and length, and appointments were offered at a convenient time and location to the women.
- Additional services were also provided included parent preparation and labour classes, hypnobirthing, breastfeeding support groups and regular coffee mornings.
- Complaints were minimal and were reviewed and actioned appropriately in a timely manner.
- People who used the service told us that continuity of care from staff was excellent.

However we also found that:

Summary of this inspection

- The service had not carried out a needs assessment of the local community it provided a service to.
- Leaflets and information sheets we looked at did not have review dates on so we could not be sure they were up-to-date.

Are services well-led?

We have not rated the well-led domain. We found:

- There had not been a registered manager in post since July 2015, and at the time of our inspection, there was no ongoing action to employ one.
- There had also been no clinical manager based at the Essex service since November 2016 since the previous manager resigned from their post. This meant that 12 midwives, three midwifery support assistants (MAMAs) and an operations manager worked without clinical management presence. Staff told us that there was one clinical manager in the North West location; who line managed them and was accessible via telephone as required. However two senior managers also confirmed that this clinical manager only visited the Essex service bi-monthly.
- Our concerns about a lack of registered manager and clinical manager were heightened given the issues we have identified including; a lack of staff one-to-one meetings taking place, and numerous concerns we have reported under the “Safety” section of this report including lone working arrangements, medicine management, skill mix, lack of infection control audits, record keeping and staff were not using the MEOWS system.
- The services risk register did not mention who was accountable for each presented risk, and correlating action plans to the risk register were not updated following risk register review.

However we also found:

- All staff we spoke with knew the provider’s vision and set of values.
- There was a clear governance process in place including a risk register, monthly “Quality Assurance Groups” and a clinical dashboard, which was well monitored.
- Staff spoke highly of their seniors within the organisation, saying they were encouraging, supportive and friendly.
- The service had processes in place for public and staff engagement.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- There was an up-to-date consent policy in place dated February 2015 with a review date of February 2017. This included guidance for staff on obtaining valid consent, refusal to consent, children under 16 years and details about the Mental Capacity Act (MCA, 2005).
- Training on the MCA and deprivation of liberty safeguards (DoLS) was part of mandatory training. Records showed that 100% of staff were compliant with training. We asked three members of staff about these terms and they were able to demonstrate that they understood them sufficiently and would act in a accordance with the legalities involved.
- Fraser Competent is a term used to describe children less than 16 who are considered to be of sufficient age and understanding to be competent to receive contraceptive advice without parental knowledge of consent. We asked three midwives about their understanding of the law relating to Fraser Guidelines, however, they did not demonstrate they understood this sufficiently.

Maternity

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are maternity services safe?

We have not rated safety as a domain. We found:

Incidents

- There were no Never Events reported by the service between December 2015 and December 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- There were 112 clinical incidents had been reported between December 2015 and December 2016, of which one was classed as a serious incident. The serious incident occurred in August 2016 due to an unexpected admission to the local neonatal unit.
- The provider maintained a monthly 'Incident Overview Report', which allowed oversight of risk across the organisation, including reported incidents rated according to cause, harm and severity. We checked one of these reports dated November to December 2016 and types of incidents reported included communication issues and shoulder dystocia.
- Review of incidents and mortality and morbidity were also standard agenda items at the provider's quarterly "Quality Assurance Group" meetings. We looked at the minutes from these meetings dated August, September, November 2016 and saw evidence of this and that meetings were well attended by senior midwives and the consultant obstetrician. We saw evidence that information from these meetings was disseminated to all levels of staff through management and local team meetings.
- There was an incident reporting system in place, and a supporting up-to-date incident reporting policy was available to staff electronically.
- We spoke with eight members of staff and they demonstrated to us that they understood their responsibilities to raise concerns and to record safety incidents, concerns and near misses. They also told us they were encouraged to report incidents.
- Staff told us they could easily access the electronic reporting system to report incidents, and gave us examples of where they had reported incidents and received feedback.
- There was evidence of learning from incidents beyond the affected team. For example, following one serious incident which involved an unexpected neonatal admission to the local special care neonatal unit, it had been identified that the midwife did not accompany the ambulance crew on the emergency neonatal transfer, which is necessary to aid handover of care to hospital staff. We spoke with three midwives and they were aware of this incident and told us that they would always accompany emergency neonatal admissions. This showed lessons had been learnt.
- Lessons learnt were also shared through the provider's intranet (internal internet) pages.
- Root cause analysis investigations (RCA) were completed as part of the investigation of significant or serious incidents. A senior manager told us that RCA investigations were only completed by staff who had received formal RCA training, and that four members of the senior leadership had completed such training.
- We reviewed one RCA investigation which related to the serious incident reported in August 2016, and found that

this had been thoroughly investigated, all relevant staff and people who used the service were involved in the investigation, and lessons learnt were identified and an action log in place.

- There was a policy in place regarding the Duty of Candour, which was due for review in May 2017. The Duty of Candour is a legal duty on health organisations to notifying the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- Senior managers were able to describe past incidents, which had let to the correct application of the Duty of Candour, and we saw documentary evidence to support this.
- Staff confirmed they had received Duty of Candour training, which was delivered by the provider during their induction programme, and that they were aware of the terminology and their role in regard to the legislation.

Safety thermometer

- The Maternity Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm, such as perineal and/or abdominal trauma, post-partum haemorrhage, separation from baby and psychological safety.
- Managers told us that each month the provider collected Maternity Safety Thermometer data for women who had a homebirth, which equated to about 25% of women booked with the provider nationally. This meant that input into this system was too small to report and subsequently the provider could not provide evidence of outcome at the time of our inspection.

Mandatory Training

- There was a comprehensive mandatory training programme in place for all staff which included statutory training and training relevant to staff's individual job role.
- Senior managers told us that they monitored staff's compliance with mandatory training regularly, and an up-to-date training spreadsheet we saw assisted with oversight of this.
- Records showed that 100% of all staff were up-to-date with statutory training, and 83% of midwives and 33% of maternity assistants (MAMAs) were up-to-date with their mandatory training.
- Mandatory training was divided into statutory training and other subjects, which were role specific. Statutory training for all staff included: conflict resolution, equality and diversity, health and safety welfare, infection prevention, fire safety, moving and handling, information governance, and adult basic life support (BLS).
- Mandatory training subjects for all staff included organisational culture, record keeping, risk management, Baby Friendly Initiative, screening and the unwell neonate. In addition to this midwives received skills and drills training, which was learning via simulation and included neonatal resuscitation and obstetric emergency training such as cord prolapse management, and fetal heart rate monitoring and antenatal cardiotocograph (CTG), perineal care, physiological birth – tips and tricks, supporting homebirths, mental health update and parent education and hypobirthing training.
- Staff told us that training was delivered through a variety of means including web-based training and learning via simulation (skills and drills training) for obstetric emergencies. Training was delivered by appropriately qualified people, for example, safeguarding training was delivered by the local authority, and skills and drills by a well-known expert outside speaker.

Safeguarding

- There was a safeguarding adult policy in place last updated in July 2016 and available to all staff. These contained necessary safeguarding information including how to contact the relevant local authority safeguarding team; and advice and pathways were seen relating to the Mental Capacity Act, forced marriage, honour based violence, human trafficking and PREVENT. PREVENT is part of the Governments counter terrorism strategy to prevent people becoming terrorist and supporting violent extremism.
- We also saw a safeguarding children's policy, with a review date of 2018, available to all staff. Information

within the policy guided staff about working with sexually active under 18 year olds, disabled children, Looked after Children (LAC), female genital mutilation (FGM) and child exploitation.

- We spoke with five members of staff about safeguarding. All of which correctly described what constituted a safeguarding incident, and when and how they would raise a safeguarding concern.
- Records demonstrated that each midwife had quarterly safeguarding supervision, which was face-to-face and led by a safeguarding supervisor.
- There was a safeguarding team within the organisation, who were based in the North of England. The team consisted of a safeguarding lead, a safeguarding midwife and one safeguarding supervisor. Staff could access the team via telephone or webinar.
- All safeguarding incidents were reviewed by the safeguarding and governance lead and staff told us they had three monthly safeguarding supervision, and monthly for ongoing cases.
- Training records we looked at showed that 100% of midwives had received level one, two and three training in adult and children's safeguarding, and 100% of maternity assistants (MAMAs) had received level one and two training in both of these subjects.
- A safeguarding alert system was in use within women's and babies' electronic health care records. This alerted staff to people who were at risk of abuse or where an ongoing safeguarding concern existed.
- We checked two women's healthcare records, where there had been identified safeguarding concerns, and found that safeguarding alerts were in use, that safeguarding risk assessments had been carried out, and that the provider's safeguarding team had oversight of each case.
- We spoke with two members of staff who explained the system in place to check whether families were subject to a child protection or a child in need plan, where safeguarding concerns were suspected. One staff member told us they had used this system recently, which showed that a family were known to social services, and that subsequently this member of staff contacted the health visitor for further information and tailored care to the need of mother, unborn and family.
- A manager explained to us that the service had a good relationship with the local authority safeguarding team, the Local Acute Trust and health visitors within the region, and that information sharing in relation to safeguarding cases and safeguarding updates were good. Numerous documents we looked at reflected this.
- A senior manager told us that a new safeguarding dashboard was being developed to assist the safeguarding team's oversight of all safeguarding cases; this was due to be implemented mid-2017.

Cleanliness, infection control and hygiene

- There had been no cases of Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile reported between December 2015 to December 2016.
- There had been a recent audit of birthing pools dated December 2016. This audit showed that 4% of pool liners became split or damaged during use; less than half (45%) of staff ticked the usage box on the pool and were aware of how many times the pool had been used (the provider's policy stated it could be used up to 20 times).
- Results of the audits had led to the development of an action plan, which included birthing pool maintenance being covered in mandatory training for all midwives, and that the audit would be repeated annually. We however were concerned that a visual inspection of the cleanliness of pools, and midwives understanding of cleaning of the pools, was not incorporated into this audit.
- Other than the birthing pool audit, the service did not carry out any other infection control and prevention audits. A manager confirmed our findings. This meant that cleanliness, infection control and hygiene were not being sufficiently monitored.
- There were infection prevention and control policies and procedures in place that were readily available to staff electronically, including an up-to-date birth pool policy and procedure. Staff explained to us that they provided care and treatment in accordance with these policies, for example, that birthing pools were maintained and cleaned in line with the provider's policy and procedures, which we read.

Maternity

- Records showed that 100% of staff were compliant with infection prevention and control training. This training was mandatory and delivered annually.
- There was an up-to-date Service Level Agreement (SLA) in place with an external organisation for waste management. Clinical waste was collected regularly throughout the week by the company, and we observed that it was stored appropriately beforehand.
- We saw clinical and domestic waste bins were available and were used appropriately. Sharps bins were also in use, which were seen as not overfilled and correctly labelled. As midwives worked predominantly in the homes of women who used the service, clinical waste was transported back to the service premises by the midwife for appropriate waste management. For example, midwives bought placentas from homebirths, which were double-bagged, and these were stored in the service's fridge before clinical waste collection.
- Areas we visited were tidy and clean. We observed a fridge which was used for storing placentas after childbirth, since these were collected a few times a week by the waste management company via SLA. This fridge was visibly clean; however, there was no cleaning record in place to show that cleaning had been carried out, a member of staff confirmed that cleaning wasn't logged.
- We saw that staff had access to necessary person protective equipment (PPE) such as gloves and aprons, and could restock their bags as required. This equipment was available in the store room which staff told us they could access 24 hours a day seven days a week.

Environment and Equipment

- The service operated from The Abbey Field Medical Centre and rented one small store room and Entonox (Nitrous Oxide) storage facilities here. At the centre they also had access to a computer/meeting room as required, and one computer desk at all times. Staff also told us that the service could rent a consulting room at the centre, as needed and when the provider's obstetric consultant carried out clinics.
- We saw that there were adequate storage facilities and staff told us they had access to all the equipment they required to carry out their role effectively.
- We checked twenty pieces of disposable equipment and found that packaging was intact and the expiry date had not passed.
- Records we reviewed showed that equipment, such as midwives sonicaids, had been serviced according to manufacturer's instructions and electrical equipment had been portable appliance tested (PAT).
- Four midwives told us they all carried a variety of blood pressure cuff sizes. This meant that a correct cuff could be used for different sized women, including those with a high Body Mass Index (BMI).
- Community midwives carried necessary emergency equipment, including a home birth box with neonatal resuscitation equipment. There were checklists in place, which the midwives used to ensure their home birth boxes were restocked after use. We checked one home birth box and found that all the required equipment, as per the checklist, was in place.
- We saw that Entonox (Nitrous Oxide) cylinders were stored safely at the premises, and staff told us that they could access this store 24 hours a day seven days a week, as required. We however were concerned that two midwives told us that Entonox cylinders were transported loose in bags to homebirths, in their cars, without being secured in anyway. This meant that the service was not following national safety guidelines which state; "Cylinders are to be secured so that they cannot move during transport" (British Compressed Gases Association (BCGA) Guidance for the carriage of gas cylinders on vehicles; Revision 1, 2015).
- The service used a cardiotocograph (CTG) machine, which is used to monitor fetal heart rate and maternal uterine contractions during pregnancy. Records sent to us by the provider showed that this piece of equipment was new and therefore no servicing was required until a year of receiving the equipment. Staff told us that the CTG was used only for the first occasion of reduced fetal movements to check fetal wellbeing, and we saw that staff had access to an up-to-date policy to support antenatal CTG practice.
- At times midwives were required to attend the building alone, where the service's premises were, when the building was closed or empty, for example, in the middle of the night if there was a home birth and the midwife required Entonox. Three members of staff

confirmed this practice. We checked the provider's "Lone Working Policy" dated January 2017, and found that this made no reference to staff entering closed or empty buildings. We also asked to see a copy of the risk assessment for this practice; however, a senior manager told us this had not been undertaken. This meant we were not assured that the provider was taking all necessary steps to ensure the safety of their employees who lone worked.

- At our follow up inspection on 06 February 2017, we saw that a draft risk assessment had been carried out and was awaiting approval by a health and safety advisor. Two midwives told us that they had not been informed of a change in practice in relation to entering the building alone or collecting Entonox. We were concerned that a change in practice had not been agreed in a timely way since us raising these concerns.
- Staff told us that if there were concerns about a women's partner, another family member or pet in the women's home, a risk assessment would be carried out and if deemed safe to visit, staff would attend in pairs.
- We were concerned that midwives diaries were hand written and that other members of the team did not know the whereabouts of their colleagues during the day. There was no record of midwives planned activity neither at the base nor via the electronic healthcare records system. Four members of staff confirmed this.

Medicines

- There was an up-to-date "Medicines Management" policy in place which was last reviewed October 2015. Staff could access this policy electronically.
- The service did not have a Service Level Agreement (SLA) for pharmacy arrangements. Instead they purchased medicine directly from a local and accredited supplier. The service only purchased necessary medicines from the Midwife Exemption List.
- There was one fridge used for medicine storage. We checked this fridge and saw that it was at the correct temperature. Records from December 2016 to February 2017 showed that the fridge temperature was checked regularly.
- We checked ten random stock medicines and found that these were stored appropriately and were in date.
- Staff told us that the service did not supply and store controlled drugs, however, we were concerned when one midwife told us that if a women requested Pethidine analgesia (pain relief which is a controlled drug) for labour, then a local GP prescribed this, the medicine stayed in the pregnant women's house until labour then the midwife administers, or disposes of the medicine if not used. Two members of staff confirmed this practice and also told us that any Pethidine waste was not recorded.
- We raised our concerns to two senior managers who told us that this practice was not in line with the service's medicine management policy, and that they would take immediate action to communicate to staff that this practice is not acceptable. We however later checked the policy titled, "Medicines Management Policy (version 2)" dated October 2015 and found that this contradicted what the managers had told us. This policy stated that, "Only medicines listed on the Midwives Exemption List may be used by the midwife", of which "Pethidine Hydrochloride" was on page 21 of this policy. This meant that the policy did not reflect the provider's intention.
- Records showed that monthly medicine audits took place to determine stock remaining and stock required. The service had recently introduced a check-in and check-out medicine system, to show when midwives removed medicine from the store.
- We reviewed the provider's "Management of the third stage of labour policy" version two, issued December 2016. This policy stated that one ampule of Syntocinon (a trade name for Oxytocin) should be administered for the active management of the third stage of labour (drugs used to deliver placenta), however, it also stated that, if management changed from physiological (no drugs used) to active management then another medicine called Syntometrine (Oxytocin and Ergometrine) should be administered. There was no comment in the policy as to why this alternative existed. We asked three midwives what medicines they routinely offered to women for the third stage of labour, and all three members of staff told us different answers. One midwife said they always offer Syntometrine, another said Syntocinon and the third midwife said it depends on the women's blood pressure.

Maternity

- The National Institute of Health and Clinical Excellence (NICE) suggest that, "For active management, administer 10 IU of oxytocin by intramuscular injection with the birth of the anterior shoulder or immediately after the birth of the baby and before the cord is clamped and cut. Use oxytocin as it is associated with fewer side effects than oxytocin plus Ergometrine". (NICE, Intrapartum care for healthy women and babies, CG190, 2014). This meant that staff were not following the provider's policy, and that the provider was not ensuring its policy and procedure was reflective of evidence-based practice.
- We asked three midwives about Entonox (Nitrous Oxide) and found that this gas was stored and administered safely, in line with the provider's "Entonox; Standard Operating Procedure" dated October 2015.The midwives confirmed that they always carried two full cylinders of Entonox to ensure the supply of gas was sufficient for a labouring women. Records showed that Entonox cylinders were signed in and out from the storage facility by midwives.
- We checked the healthcare records of five women who had used the service and found that allergies were clearly documented throughout and that medicine was administered correctly.

Records

- Staff had access electronically to an up-to-date "Record Keeping and Handheld Records Policy" issued February 2014, which was due for review in February 2017.
- We saw that women and babies healthcare records were managed in accordance with the Data Protection Act 1998. Records were kept securely preventing the risk of unauthorised access to patient information.
- A combination of electronic and paper healthcare records were used for women and their babies. This were designed by the provider. Women carried their hand held paper records, and replicated electronic records were also stored on the service's electronic healthcare record database of which only authorised staff had access to. A manager told us that the paper and electronic record were meant to replicate one another, since recent introduction of the comprehensive paper record system used covering antenatal, intrapartum (where necessary) and postnatal care.
- The provider supplied all staff with an electronic tablet so as they could access the electronic healthcare records system where they had internet connection. We saw that these were encrypted to ensure security, and staff told us that access to the electronic healthcare record system was good.
- We reviewed the healthcare records of seven women and babies who had used the service. We found that documents were dated, time recorded, with a signature and identifiable member of staff's name present; incorporated women's choices. Care plans were individualised and comprehensive and referrals to specialist services were documented. When a woman accessed consultant care, the consultant's clinical records were seen to be integrated into the woman's maternity record.
- We however were concerned that people's electronic and paper healthcare records did not reflect one another and often contained conflicting information. For example, one pregnant woman who used the service had a history of a high Body Mass Index (BMI) and a mental health condition. In the woman's paper handheld records there was no mention of the previous mental health history and the pregnancy was marked as "low risk midwifery led", and in this same person's electronic records the high BMI and mental health conditions were correctly noted and assessed, however, the pregnancy pathway appeared to be a "high risk consultant-led" pathway, given the consultant input, although this was not recorded anywhere.We showed these records, and two other records with similar concerns, to a senior manager who confirmed our findings.
- At our follow up inspection on 06 February 2017, we checked the healthcare records of two women who had used the service and we found similar concerns.
- We were also concerned that we saw no postnatal handheld records for any of these seven women or babies. This concerned us because if postnatally the women or baby deteriorated in terms of health and attended an acute hospital, hospital staff would not have had any information relating to the postnatal period.

Maternity

- The service used child red books, which are nationally used, personalised child record given to each parent/ carer at the child's birth to record the child's health and development throughout childhood.
- We saw that there was a system in place for the receiving of blood test results for women, and that the midwife updated the relevant women's records and took necessary action in a timely way.

Assessing and responding to patient risk

- There was clear inclusion and exclusion criteria in place; setting out safe and agreed criteria for accepting pregnant women who booked their maternity care with the service.
- Women who had certain past medical history such as epilepsy requiring convulsants and, or, existing hypertension requiring medication and routine medical input, were referred to the hospital for care and the referral not accepted. However, women with other risk factors such as complex social history, or previous caesarean section, were accepted and offered shared midwifery and consultant-led care.
- Records showed that the provider had based this inclusion and exclusion criterion on the antenatal definition dataset issued by the Department of Health (DoH, Payment by Results (PbR); Pathway funding system for maternity services, 2012).
- Midwives told us that they had a laminated copy of a Modified Early Obstetric Warning Score system (MEOWS) prompt chart. We saw a copy dated November 2016. This reminded staff of the set observational parameters and when they needed to escalate scores and take action. A MEOWS is a nationally recognised tool based on a simple scoring system in which a score is allocated to physiological measurements (for example blood pressure and pulse) already undertaken. The scoring system enables staff to identify patients who are becoming increasingly unwell, and provide them with increased support.
- Midwives received emergency scenario training as part of their skills and drills training, which was mandatory and completed annually. 100% of midwives were compliant with this training. Skills and drills included but was not limited to; post-partum haemorrhage, shoulder dystocia and cord prolapse training.
- Additional training included training on screening, Baby Friendly Initiative, the unwell neonate, fetal heart rate monitoring and ante-natal cardiotocograph (CTG), perineal care, physiological birth – tips and tricks, supporting homebirths, hypnobirthing and mental health updates. 83% of all midwives were compliant with this listed training. However midwives told us that they had not received training by the provider in relation high risk pregnancies, on subjects such as diabetes despite caring for high risk women regularly.
- Two managers told us that staff should be completing MEOWS scores for postnatal women's observations. They also confirmed that a MEOWS audit was not carried out.
- However when checked the healthcare records of seven women who used the service we found that MEOWS charts were not in use, not were MEOWS scores calculated.
- One woman was seen to have a day six postnatal pulse rate of 106 beats per minutes (bpm), this is above the normal range and should have triggered an alert but it did not.
- There was a pathway in place titled, "Midwives Mitigating Risk Pathway" last reviewed February 2016, and an "Escalation of Care Policy" dated April 2016. We saw that these were up-to-date and clearly outlined the procedure for necessary referrals to other professionals, and the transfer to secondary care (hospital) if the women or baby's condition deteriorated. We spoke with five members of staff and they were all aware of these policies and through discussion demonstrated they practiced in accordance with them.
- We checked the healthcare records of seven women who had used the service and found that risk assessments were carried out at booking (around 10 week's pregnancy) which included a detailed social, medical and maternal mental health assessment.
- Ongoing risk assessment, review and revision of care plans were completed as necessary throughout the pregnancy. There was also evidence of referral to specialists as required, for example one woman had been referred to the Local Acute Trusts' LAT) specialist mental health midwife, and to a consultant obstetrician due to assessed risk factors.

Maternity

- We were concerned that pregnancy pathways were not always correctly classified as high or low risk. We checked the healthcare records of three women who had used the service and found that both their electronic and paper records indicated that their pregnancies were low risk. The records of all three pregnancies should have been termed high risk. For example, one woman had a history of postnatal depression and had a previous caesarean section, and opted for a vaginal birth after caesarean section (VBAC) home delivery. These were significant risk factors and her care pathway should have been termed high risk.
- Four members of staff we spoke with explained that they would contact the clinical lead, Supervisor of Midwife (SoM) and the internal safeguarding team for those women with high risk factors wanting a home birth or for those declining care or wishing to have a free birth. They told us that thorough discussions took place and comprehensive care plans were developed with the woman, and such plans were communicated across the multidisciplinary team.
- Seven babies were Born Before Arrival (BBA) – that is at home and before the midwife attended between April 2016 and December 2016. There is no national comparator for this, however no concerns were noted with the care provided.
- Between April 2016 to December 2016 96.7% of booking appointments were undertaken before 12 weeks and six days of pregnancy. This was above the national expectation of 90%. The 'National Institute of Health and Clinical Excellence' state that booking should be undertaken before 10 weeks of pregnancy, however, the service did not measure this.
- A manager told us that there were pathways in place with the local acute trust via Service Level Agreement (SLA) for sharing information. For example, when a woman booked with the One to One service, had significant risk factors or had delivered their baby, this information was shared between the two services.

Midwifery staffing

- There were 12 midwives, three maternity support workers and one operations manager who worked within the One to One Essex service provision. The midwives and maternity support workers worked primarily in three different teams covering different geographical areas; however, staff told us that the three teams also worked together to support one another as required.
- Staff told us that teams were well mixed to ensure good skill mix, for example, there was an experienced midwife in each of the three teams.
- We were also told by staff that they had access to a Supervisor of Midwives (SoM) and clinical lead 24 hours a day 7 days per week. The SoM to midwife ratio was 1:12; this was better than the recommended 1:15 ratio set by the Nursing Midwifery Council (NMC).
- The midwife to birth ratio was a maximum of 1:32 women for full time employees, though records showed that midwives had a much a smaller caseload than this. Midwives told us that they had a manageable caseload allowing them to be able to deliver safe and effective care. There was also a cap on the number of women due to birth each month per caseload.
- Managers told us that agency and bank staff were not used and that sickness cover was covered internally if needed.
- The service also employed three maternity assistants (MAMAs) to help and support midwives to provide high standards of care to women, their families and babies before, during and after birth. The MAMA role involved care delivery and promotion of health and wellbeing, through a variety of ways including leading group sessions on subjects such as hypnobirthing and offering women individual breastfeeding support in women's homes.
- The provider had developed a volunteer programme which covered the Essex service, for women wanting to gain maternity work experience or to give back to their community.

Medical staffing

- The service employed one obstetric consultant directly who provided antenatal consultant led clinics in the community. We checked the provider's "External Consultant Agreement" document, which stated that the consultant was contracted to work a minimum of 8 hours of clinical time per week across the organisation.
- The consultant participated in the review and development of clinical policies and procedures, attended monthly 'Quality Assurance Group' meetings, reviewed plans of care, and provided advice and support to staff via telephone as required.

Maternity

- A senior manager told us that on average the consultant carried out one clinic every six weeks for the Essex service.
- During labour midwives referred women, and postnatally women and babies, to the Local Acute Trust (LAT) for consultant review as necessary.

Major incident awareness and training

- There was a 'Business Continuity Plan' (BCP) in place dated January 2017, which set out the steps the provider would take to "survive disaster" and or any situation that may lead to service disruption. This included but was not limited to: denial of access to business premises, loss of a significant member of staff, failure of information system or network and loss or travel ability. Senior managers we spoke with were familiar with this BCP.
- Fire awareness was part of statutory training for all staff, of which 100% of staff had completed this training within the past year.

Are maternity services effective?

We have not rated effective as a domain. We found:

Evidence-based care and treatment

- Relevant and current evidence-based guidance, standards, best practice and legislation were identified through the governance team, and developed and ratified by allocated staff dependent on subject.
- Staff were able to access national and local guidelines through the service's intranet, of which all staff could access via their work electronic tablet device.
- We checked nine of the services policies and procedures. With exception to the 'Management of the third stage of labour' policy, which we have written in detail about under the "Safe" section of this report, we found that all policies and procedures were based on relevant evidence-based practice and ratified appropriately.
- For example, we reviewed the service's policy titled, 'Group B Streptococcus' issued July 2016, which outlined the management of Group B Streptococcus. This policy was in date with a review date of July 2019, and made reference to up-to-date guidelines and research published by professional bodies such as 'The National Institute of Health and Clinical Excellence' (NICE); 'The Royal College of Obstetrics and Gynaecology' and 'The UK National Screening Committee'.
- Whilst the majority of policies were up to date, some were found to be out of date including the provider's policy for the prophylactic use of Anti D, which required a review in 2008.
- There were guidance documents available to staff called "Practice Points", which were developed in conjunction with staff, to guide staff with different elements of practice to ensure evidence-based practice. We checked two "Practice Point" documents relating to reduced fetal movements and vaginal birth after caesarean section (VBAC); these were reflective of current national guidance.
- There were clinical pathways and protocols in place for the management of low, intermediate and high risk pregnancies. We checked the healthcare records of five women who used the service and found that their care followed the relevant pathway according to their assessed needs. However, we also found that it was not clearly identifiable what the pathway title was from the women's handheld of electronic healthcare records. We have discussed this further under the 'Records' subheading of the 'Safe' section of this report.
- We examined five healthcare records of women who had a homebirth. We found that in all cases the fetal heart rate (FHR) was monitored in line with NICE (Intrapartum Care for Healthy Women and Babies; CG190, 2014).
- Where care had not been delivered in line with NICE guidelines, the reason had not been recorded. Three out of five records we examined showed that a vaginal examination had not been performed in labour, however, the reason for this was not recorded in either the women's handheld or electronic records. NICE guidelines state that, 'If the woman appears to be in established labour, offer a vaginal examination', and thereafter, 'four hourly or if there is a concern' (NICE, Intrapartum Care for Healthy Women and Babies; CG190, 2014). Therefore, we could not be assured that the service was following evidence-based guidance at all times such as this.

Maternity

- A documentation audit had been carried out in December 2016. The audit looked at 22 sets of randomly selected handheld and electronic records. Results showed that 100% of women had their needs assessed at booking and by 12 weeks pregnancy; and "In the majority of women who required an onward referral the midwives evidenced a management plan". This audit was scheduled to be repeated six months' from the initial audit, and there was an action supporting further monitoring or improvement.

Nutrition and hydration

- We looked at the healthcare records of five women, and found evidence that at booking nutrition had been assessed and discussed; hydration had been checked regularly in labour if the women delivered at home; and food and hydration intake recorded after delivery.
- On the provider's website page there was access to up-to-date evidence-based information regarding what to eat and drink during pregnancy. Leaflets were also available.
- The maternity assistants (MAMAs) provided additional breastfeeding support and as much as a women required. Women also had access to a coffee morning, which the service provided, three times a month where breastfeeding support was available.
- We checked the healthcare records of five women who used the service and found that infant feeding had been discussed, breastfeeding promoted, and an antenatal feeding plan was recorded.
- Data from April to December 2016 showed that breastfeeding rates for women were86.5% for women who delivered and breastfed their babies within 48 hours of birth, and 51.4% of women were still breastfeeding their babies at 10-14 days postnatal.
- The service was not Unicef UK Baby Friendly Initiative (BFI) accredited and there were no immediate plans to apply for this in the future. However the service did show that it worked towards achieving some of the BFI programme. 'Baby Friendly accreditation is based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services' which is assessed externally at varying stages by Unicef UK (Unicef, Accreditation, 2017).
- Meeting minutes dated November 2016 showed that the provider participated in an "Infant Feeding Strategy Group" with the local region, which was led by another organisation who provided child health services, including health visiting.
- We spoke with three midwives about jaundice and weight loss in babies, and they confirmed that they followed national guidance issued by bodies such as NICE relating to these subjects. Staff told us that in the Essex area jaundice checks did not involve blood samples.

Pain relief

- The methods of pharmacological pain relief available for labouring women at home were Entonox (Nitrous Oxide) and paracetamol. Midwives had access to Entonox 24 hours a day seven days per week.
- Women were made aware of the pain relief options at booking and if they required alternative pain relief options, such as pethidine or an epidural, they were planned as a hospital birth, or during labour transferred to hospital.
- Non-pharmacological pain relief included immersion in water (pool births), hypnobirthing and aromatherapy. Records showed that 83% of midwives had received training in hypnobirthing.

Patient outcomes

- The provider had an annual audit programme, which included audit of the management of hypertension; continuity of care; intrapartum transfer; perineal trauma and documentation. In addition records showed that all new midwives to the organisation had their clinical records audited monthly while on preceptorship. During the reporting period March 2015 to April 2016 the provider carried out 14 internal clinical audits.
- We reviewed the provider's 'Antenatal and Newborn Screening' audit results from 2016. The aim of the audit was to measure compliance against national standards for the six UK National Screening Committee (UKNSC) antenatal and newborn screening programmes focussing on the offering of screening and consent to screening. The sample used was 20 women who booked for maternity care with One to One (North West) Limited in July 2015. Results showed that 16 of the 20 records recorded offers of antenatal screening; 18 out of 20

women were given written information. The audit also highlighted some areas for improvement, which led to the development of an action plan which was being progress against was being monitored.

- Data the provider sent to us before our inspection stated that, 'while One to One did not have the opportunity to take part in national audit [they] have taken part in the open and honest campaign and published [their] data through the national safety thermometer'.
- The service used a maternity dashboard which was red, amber and green (RAG) rated with set parameters for outcomes measured. We looked at the data from the dashboard for the Essex service from April 2016 to December 2016. The dashboard measured quality standards for maternity and included monthly and cumulative rates for the latter reporting period for numerous outcomes.
- Cumulative data from this maternity dashboard showed that during April 2016 to December 2016 there had been 208 women delivered and 213 live births, of which; 39.9% were planned homebirths; 27.9% were achieved homebirths; 64.4% were normal vaginal deliveries; 11.1.% were instrumental deliveries; 13.5% emergency caesarean section and 11.1% elective caesarean section deliveries.
- There had also been no unexpected admissions of babies to the neonatal intensive care unit; no unplanned maternal admission to the intensive care unit; and other data presented on the dashboard showed women smoking at delivering at booking (6.9%) and delivery (2.9%); water births (31); intrapartum transfers of all births (6.7%); post-partum haemorrhage 500-999mls (6); third and four degree tears (0), shoulder dystocia (4); low birth rate at term (0); stillbirths (0); transfer of babies to the neonatal unit (0).
- From the women who started as a home birth the data also showed that the normal birth rate was 92.1%, caesarean section rate was 3.9% and instrumental birth rate was 3.9% during the same reporting period.

Competent Staff

- We reviewed three members of staff's pre-employment records, which showed that suitable pre-employment checks were carried out for staff, including Disclosure and Barring Service (DBS), referencing and professional registration checks.
- Staff members' professional registration status was checked pre-employment and annually thereafter. These staff members included midwives and the consultant obstetrician.
- Records showed that new employees undertook both a corporate and local induction programme. Each new member of staff that joined the organisation was allocated a mentor, had monthly meetings between the member of staff and mentor took place for a period of 12 months, new starters were also given a competency framework specific to their role, to work through.
- For newly qualified midwives joining the organisation there was a preceptorship programme, the period of induction and preceptorship was 12 months. We checked the preceptorship and induction programme, and competency frameworks for new starters and found these were being adhered to.
- We spoke with three new members of staff and they confirmed that they had an allocated mentor, met with them regularly, and were working through their competency framework. All three members of staff told us that they were very well supported by their mentor and other staff members. One midwife told us, "It is excellent here, I feel really supported by my colleagues and the managers at One to One".
- Managers told us that staff were provided with ten days protected time per annum to attend training. Two new midwives told us that they had been booked on to some additional training and were waiting to complete this.
- A manager told us that there were two midwives trained to complete the newborn baby (NIPE) checked which is a necessary health and wellbeing check carried out within 72 hours of birth. One other member of staff told us they were booked onto complete this training to which was to be funded by the provider.
- We were concerned that records showed that midwives had not completed training on vaginal birth after caesarean section (VBAC). Four midwives we spoke with confirmed this. There had been 23 VBAC home deliveries between April 2016 and December 2016.
- Records showed that 83% of midwives were competent in perineal suturing.

Maternity

- A senior manager told us that they were responsible for checking the employed consultant's revalidation status, in relation to registration as a doctor, and for competing the consultant's annual appraisal. They told us that this consultant worked at an NHS Trust, near to the provider's headquarters and that the consultant performed the same role there.
- Records showed that 86% of midwifery and support staff had received an appraisal in the past year. Staff told us that learning and development needs were identified during appraisal and that they were supported with their learning by their line manager.
- We were concerned that six members of staff told us they had not had regular one-to-one meetings with a manager since the previous clinical manager had left their post in November 2016. This meant that staff were not being supported appropriately. Staff did however tell us that they had access via telephone to a clinical manager and Supervisor of Midwives (SoM) 24 hours a day seven days a week for support. The clinical manager and SoM was based in the provider's other location in Birkenhead, North West England.
- Due to the absence of a local manager and a lack of one-to-one meetings for staff, we were not assured that poor or variable staff performance may be identified and managed appropriately.
- Of the 12 midwives employed; three were newly qualified, four had been qualified for just over a year and joined the provider as newly qualified midwives, and five had been qualified for between five and ten years. This meant that seven of the 12 midwives were either newly qualified or had limited midwifery practice experience.
- All maternity assistants (MAMAs) were NVQ level 3 trained and received appropriate training before they were assessed as competent to work alone. They also received a development programme framework, which was to be completed six week following the MAMA training.
- The provider employed five Supervisor of Midwives (SoM) who were based in the North West of England. This equated to a 1:12 SoM to midwife ratio, which was better than the recommended guidance (1:15). At the time of this report, supervision of midwifery was under review nationally and One to One (North West) Limited had been chosen as one of the six pilot sites to test a new model of supervision.

Multi-disciplinary working

- Where it was necessary, women were referred to relevant members of the multidisciplinary team. For example, pregnant women were referred to sonographers for routine pregnancy ultrasound scanning (USS), and to the local acute trust (LAT) consultant and specialist midwives if certain risk factors had been identified.
- Staff told us that there was a good working relationship with the service's obstetric consultant, and that they felt able to contact the consultant directly as required.
- Overall staff reported good multidisciplinary working with other services, such as the local authority, the ambulance services, the LAT, general practitioners (GPs), Family Nurse Partnership (FNP) specialists, and the health visiting (HV) team. Staff gave examples of cases of care that involved each of these healthcare professionals.
- There were agreements in place to ensure that the LAT, HVs and GPs were involved in care, and aware of bookings, high risk cases and discharge from the service. For example, we reviewed the 'Partnership Working Agreement' between the provider and a LAT, which was for, 'The dissemination and implementation of communication and clinical pathways'.
- We were shown numerous records which demonstrated that the provider attended a variety of local meetings and worked in partnership with other organisations. For example, in October 2016 the provider attended a recent meeting at a local LAT to discuss the provision of maternity services locally.Also in October 2016 a representative from One to One (North West) Limited attended a 'Children and Maternity Programme Board Meeting' held by a local Clinical Commissioning Group.
- The provider had introduced 'Situation, Background, Assessment, Recommendation' (SBAR) handover forms to assist effective communication between the multidisciplinary team. Staff told us they used this tool as required.

Seven-day service

- The community-based midwives provided care 24 hours a day, 7 days a week, for 52 weeks of the year.
- We spoke with four women who used the service and they told us that they could access a midwife from the service 24 hours a day seven days a week.

- Records showed that there was always a midwife on duty within the Essex service, and that there was a clinical lead available for advice and support in the North West area at all times to.
- The consultant obstetrician provided antenatal care consultations in the Essex area every six weeks or more often as required. This consultant was also available for advice regularly via telecom.

Access to information

- We spoke with nine members of staff who told us they had access to the electronic healthcare system used, and could therefore access all the records of women and babies cared for by the provider.
- During our visits we requested the electronic and paper healthcare records of eight women and babies and these were supplied to us promptly.
- Staff we spoke with told us there was good communication between internal and external staff, and that blood and scan results were in the women's handheld records and if they were not they could contact the relevant external organisation and had this information to hand promptly.
- Staff told us they had access to all the clinical information and guidance they required via their work electronic tablets.
- We saw that there was an electronic system in place for the sharing of discharge summaries from the service to local health visitors and GPs.

Consent Mental Capacity Act and Deprivation of Liberty

- There was an up-to-date consent policy in place dated February 2015 with a review date of February 2017. This included guidance for staff on obtaining valid consent, refusal to consent, children under 16 years and details about the Mental Capacity Act (MCA, 2005).
- Training on the MCA and deprivation of liberty safeguards (DoLS) was part of mandatory training. Records showed that 100% of staff were compliant with training. We asked three members of staff about these terms and they were able to demonstrate that they understood them sufficiently and would act in a accordance with the legalities involved.
- Six members of staff were able to describe the correct process for obtaining valid consent, and confirmed that policies and procedures were available via the intranet to support these issues.
- Fraser Competent is a term used to describe children less than 16 who are considered to be of sufficient age and understanding to be competent to receive contraceptive advice without parental knowledge of consent. We asked three midwives about their understanding of the law relating to Fraser Guidelines, however, they did not demonstrate they understood this sufficiently. For example, one midwife told us they hadn't looked into this before. This was a concern given that the provider was commissioned to provide care to women aged 14 years and over.
- Four women we spoke with, who had used the service, told us that they had been given clear information about the benefits and risks of their care and treatment beforehand, and in a way they could understand. They also told us that they were given sufficient time to make decisions about their care and treatment, and felt they could change their mind about decisions at any time. One person told us, "Staff were so good and informative", and another said, "They [staff] explained everything and gave me time to make decisions".
- We looked at the healthcare records of five women who had used the service and found that care plans contained detailed information about the risks and benefits of care and treatment, and consent was recorded where required. For example, we saw that informed consent had been obtained in relation to the baby receiving Vitamin K medicine in all of the three homebirth records we checked.

Are maternity services caring?

We have note rated caring as a domain. We found:

Compassionate care

- The Friends and Family Test (FFT) is a feedback tool that gives people who use services the opportunity to provide feedback on their experience. FFT results were displayed on the service's maternity dashboard and reviewed at the provider's Quality Assurance Group (QAG).
- FFT data from April 2016 to December showed a high number of people who used the service would recommend or highly recommend the service; during the antenatal (98.8%), intrapartum (99.3%) and postnatal period (97.6%).

Maternity

- FFT response rates were low and ranged between 37.6% and 51.8%.
- Alongside the FFT questions, the service also asked numerous other questions termed "supplementary questions". For example, women were asked whether they felt the midwife listened to them during postnatal contacts. Results showed 498 women were asked and 94% answered 'good'. .
- We spoke with three women who had used the service and they spoke positively of staff. One woman told us, "They [staff] are amazing, kind and caring". Another woman told us that their named midwife attended her delivery when off duty, as the midwife had cared for her continuously throughout her pregnancy and wanted to "be there" for the woman.
- On the provider's website and in their annual report 2015/2016 there were birth stories presented. The birth stories were from people and those close to them that had used the service and agreed to the sharing of their story. The birth stories we read reflected excellent care. For example, one woman in March 2016 wrote, "This whole experience with all the staff from One to One has been so amazing from start to end. I can't thank them enough and I will continue to spread the word of this amazing service

Understanding and involvement of patients and those close to them

- Four women who used the service told us they felt involved in their care and in decision making about treatment. Women were able to tell us the name of their named midwife and said they had received continuity of care from this member of staff.
- Between April 2016 to December 2016, 135 women were asked whether they felt involved in decision making during their pregnancy. Results showed that 99% of women answered yes and 1% answered no.
- Midwives told us that they spent a minimum of an hour at each contact with women and babies who used the service. This meant that they took time to interact with service users and those close to them.
- We looked at the care plans of five women who used the service and found that the midwife had empowered and supported women's individualised care plans. Three women we spoke with also told us this. For example one person told us, "I felt in control, they [staff] listened, gave me choice".
- We saw that the provider made use of a range of social media platforms to provide information to patients and to receive feedback.

Emotional Support:

- Two women who used the service told us that staff had enough time to provide them with adequate emotional support throughout their care.
- Midwives told us that they had access to specialist midwives via a Local Acute Trust (LAT), and gave us examples when they had referred women to such services. For example, one woman had a history of depression and was on medication. Her healthcare records showed that she had received appropriate and timely support from a multidisciplinary team, and had extra visits from her One to One midwife.

Are maternity services responsive?

We have not rated responsive as a domain. We found:

Service Planning and delivery to meet the needs of the local people

- The service had not carried out a needs assessment of the local community it provided a service to.
- We examined the healthcare records of seven women who used the service and found that the service provided ensured flexibility, choice and continuity of care. Care was also tailored to individual need on a case by case basis.
- The service aimed for the named midwife to attend the majority of routine antenatal and postnatal appointments with women, and to support women during labour with a home assessment and to be present at the birth for women who choose a home birth.
- Care and treatment was delivered at a place convenient to the woman and her family, an unlimited number of antenatal visits offered, scans performed in the community, flexibility of appointments between

08:00am and 08:00pm 7 days a week, triage visits including a CTG at home, weekend parent education including hypnobirthing and postnatal care up to six weeks were offered.

- We saw evidence that the service continued to work hard to build effective working relationships with stakeholders including commissioners and the local acute trust (LAT), to develop shared pathways and improve communication.

Meeting people's individual needs

- The service accepted low and high-risk pregnancy referrals. Midwives led low risk care and coordinated high-risk care whilst working in partnership with a consultant and other professionals.
- There were numerous policies and pathways in place to support the management of high-risk pregnancies. This included the 'Management of Women with Complex Needs' policy dated October 2015. Staff we spoke with were familiar with this policy.
- We checked the healthcare records of five women with complex needs. We found that the service took account of the needs of different people, including those in vulnerable circumstances; carried out necessary risk assessments and developed detailed care plans in partnership with the woman and other healthcare professionals as required.
- We saw that maternal mental health risk assessments were carried out on all women during the antenatal period, and midwives told us they had access to external perinatal mental health services including a specialist midwife at the LAT.
- Staff told us that that translation services were available as required. There was a pathway in place to support this, which stated that at first contact the midwife assessed the need for translation services. If required, the midwife was to, 'contact local interpreting services and book joint appointment with named midwife and interpreter'.
- We found that women were offered choice in care and treatment, for example, immersion in water (pool birth) during labour was available and hypnobirthing. We spoke with three women who used the service who confirmed this.
- One to One midwives offered as much antenatal, and postnatal up to six weeks, contacts with a midwife and or maternity assistant (MAMA) as the women required. They also provided 'hypnobirthing Course', a 'Bumps and Babies', 'Breastfeeding Workshop', and 'Babies Coming' classes throughout the month and in both the Colchester and Clacton areas. Furthermore, there were three 'Coffee Mornings' per month available to mothers and their babies. These were delivered by one of the MAMAs and often attended by a midwife.
- There was a range of written advice available to women and their families, in the form of leaflets, emails and via the provider's website. For example, on the website there was information about alcohol consumption in pregnancy and information about tongue-tie (which is a structural abnormality of the lingual frenulum located under the tongue).
- Leaflets about breastfeeding and healthy lifestyle were available. Whilst the content of this information appeared up-to-date, we found that there were no issue or review dates on any of the information documents we looked at, so we could not be sure they were based on current evidence-based information.
- Training records showed that 83% of midwives had received additional training in mental health.
- A manager told us that the service was in the process of allocating a bereavement link midwife, and staff told us they had discussed this at the February 2017 team meeting.
- Midwives told us that they could refer women for bereavement support to the LAT as needed, and they the One to One midwife could see women more frequently for up-to six week after delivery according to the women's needs to offer additional support.

Access and flow

- Pregnant women living within the North Essex area, were able to access the Essex One to One (North West) Limited service.
- Access to the service was either through self-referral (through the provider's website or social media), or general practitioner (GP) referral. Information about access and referral was provided on the service's website.

- There was an up-to-date Did Not Attend (DNA) policy in place for the management of women who do not attend their appointment. We saw evidence that a midwife followed this policy correctly, in relation to a high risk case and a DNA appointment.
- We asked three women who had used the service about access and flow, and they confirmed that service access had been easy, and flow had been seamless in terms of appointments.
- There was no waiting list for appointments offered by the midwives or MAMAs. Instead appointments were arranged at a time convenient for the women, to fit around the women and families lifestyle and other commitments.

Learning from complaints

- There was a complaint process in place and that the provider monitored complaints regularly. Complaints raised per month were displayed on the provider's local maternity dashboard, which was reviewed regularly at the Quality Assurance Group (QAG).
- The Chief Executive took overall responsibility, alongside the governance team, for complaint management and to ensure that the necessary action was taken to manage the complaint effectively.
- Between December 2015 and December 2016 there had been one complaint raised about the service. This was in relation to a midwife not attending a consultant appointment as planned. We looked at the record in relation to this complaint and found that it was investigated and responded to appropriately.
- Information about how to make a complaint was made available to people who used the service and those close to them. This information was in women's handheld records and they were given this at booking, via social media tabs and on the provider's website.
- There was information stating that if the complaint could not be resolved at a local level then the complainant could contact the Parliamentary and Health Service Ombudsman (PHSO). The contact details for the Ombudsman were printed in the women's handheld notes.
- Where appropriate, complaints were used to improve service provision. For example, subsequent to one complaint the service had since ensured that midwives handed over cases to one another in a timely way. Three midwives we spoke with were aware of this complaint and the subsequent change in practice, there was also a notice in the office which reminded staff of this.

Are maternity services well-led?

We have not rated well-led at domain. We found:

Vision and Strategy for this core service

- There was a clear vision and set of values specific to the community midwifery service, with quality and safety set as a top priority. We saw that the vision and set of values was embedded throughout the provider's records.
- Staff we spoke with demonstrated they were familiar with the provider's vision and values.
- The service vision was, 'To put the woman at the centre of care, respecting her human rights and the right to self-determination, empowering her to be part of the decision making process and ultimately a positive birthing memory'. Four principles formed the set of values "excellence, safety, women centre, integrity and professionalism".
- The provider was part of the 'Maternity Review' and demonstrated they were working towards to the report recommendations. The Maternity Review was commissioned nationally in 2015 to, 'assess current maternity care provision and consider how services should be developed to meet the changing needs of women and babies' (NHS England, 2017).
- A Quality and Improvement Strategy existed dated 2016-2018. We checked this document and found that the strategy contained short-term one year objectives and longer three year goals. This was a realistic strategy for achieving the priorities set and delivering good quality care. Oversight and monitoring of the strategy was carried out by the Senior Leadership Team (SLT) and the Quality Assurance Group (QAG).

Governance, risk management and quality measurement

Maternity

- There was a governance framework in place with a dedicated quality and governance team based in the North West of England.
- Staff we spoke with were clear about their roles and showed they understood what they were accountable for. We also saw a document, which mapped out governance arrangements and dissemination of information, from board level to local teams.
- There were assurance systems and service performance measures, which were reported and monitored, with action taken to improve performance. This included a risk register, maternity dashboard, a Quality Assurance Group (QAG) and Senior Leadership Team (SLT) meetings. The QAG was attended by the obstetric consultant and senior managers.
- We reviewed the provider's risk register, which was a corporate One to One (North West) Limited register however, it contained risk relevant to the Essex region. All entries had a date the risk was added, description of risk, mitigating actions and a review date. However, the person accountable for each risk was not identifiable and five of the nine risks remained unchanged, with the same information repeated since the preceding review.
- We also saw that the impact and control rating for the 'retention of midwives' risk, on the risk register, had been changed from moderate to high since the last risk register review. However, the correlating action plan had not been updated to reflect this change. Furthermore, two of the three new risks identified did not have a correlating action plan despite one risk rated as high.
- We saw meeting minutes of QAG meetings for August, September and November 2016, which established that the risk register was reviewed monthly.
- A governance dashboard was in place, specific to the community maternity service, which monitored risk, safety and performance issues. We also found that senior manager oversight of this dashboard was good, and that it was reviewed monthly at the QAG and data was fed back to the SLT. The dashboard showed that there was a holistic understanding of performance, given the extensive criteria measured, which also integrated the views of people, with information about safety, quality and activity.
- Records showed that regular team meetings took place, for all staff. We checked the team meeting minutes for December 2016 and January 2017, which showed a set agenda and good staff attendance.
- Staff told us that they had monthly 'Fresh Eyes' discussions with a clinical lead from the North West area, to go through their caseload to ensure that risk was being managed effectively. The clinical lead attended the Essex area bi-monthly for face-to-face meetings and via telephone outside of this. From these discussions, the clinical lead completed a complex care log online. These were updated monthly by the lead and allowed for oversight of complex cases.

Leadership of the Service

- The organisational structure consisted of an executive team comprising of a clinical director, head of quality and governance, head of clinical service, head of operations, head of safeguarding, head of information technology, head of finance and head of communications and engagement.
- Staff we spoke with were clear about their roles and showed they understood what they were accountable for. We also saw a document, which mapped out governance arrangements and dissemination of information, from board level to local teams.
- We however were concerned that there had not been a registered manager (RM) in post for the Essex service since July 2015. Furthermore, there had been no clinical manager since November 2016 since the previous manager resigned from their post. This meant that 12 midwives, three midwifery support assistants (MAMAs) and an operations manager worked without clinical management presence.
- Staff told us that there was one clinical manager in the North West location; who line managed them and was accessible via telephone as required. However two senior managers also confirmed that this clinical manager only visited the Essex service bi-monthly.
- Our concerns were heightened given the issues we have identified including; a lack of staff one-to-one meetings taking place, and numerous concerns we have reported under the "Safety" section of this report including lone working arrangements, medicine management, skill mix, lack of local audit, record keeping and staff were

not using the MEOWS system. These issues existed despite us raising similar concerns at our last inspection in February 2016 and issuing Requirement Notices for both safety and governance.

- Staff reported the leadership culture made them feel valued and respected. We spoke with nine members of staff and they spoke with passions and pride about working within the service.
- Staff also told us that senior leaders were approachable and encouraged appreciative, supportive relationships among staff.
- We discussed the lack of leadership with two senior managers and they told us that staff had agreed that they liked working without a manager, and the site was piloting a new model of community midwifery, which involved the absence of a leader/manager.
- The service has not had a registered manager in post since July 2015, which is a requirement under the conditions of registration.

Culture within the service

- Staff that we spoke with were very proud to work for the organisation and felt they provided excellent care to women, babies and their families. The enthusiasm and passion demonstrated was overwhelmingly good. One member of staff told us, "I love it here, it is like a family". Another member of staff said, "It is great here, really supportive".
- None of the staff we spoke with said they had experienced bullying from colleagues or managers. Staff told us they were encouraged to raise concerns and that there was a "no blame" culture.
- All staff from junior to senior, clinical and non-clinical spoke of a strong culture of openness and honesty.
- The provider had developed and 'Open and Honest Programme', which is an initiative introduced by the NHS to ensure high-quality care and to build improved services for the future. The provider joined the programme in January 2015 and published a report related to this monthly on its website.
- We observed staff interacting in a positive way with one another, they demonstrated they knew each other well, respected and supported each other and had a good working relationship.
- An annual staff survey was carried out in January 2016 and included all staff across the provider's services. At the time 91 staff were employed by One to One (North West) Limited, and of this 69 completed the survey. This survey was carried our through an external company and results were anonymous. The findings of this survey were very positive.
- For example, 86% of employees looked forward to going to work; over 94% were enthusiastic about their job; 92% of employees had never experienced harassment of bullying; 98.5% have not experienced discrimination; 82% said that their manager takes a positive interest in their health and wellbeing; 84% felt there were opportunities within their role to show initiative. Areas from improvement were also highlighted which included; staff appraisals rates (57.58%), however, we saw that there was an action plan in place to address this.
- There had been no reported staff sickness between December 2015 and December 2016.

Public and staff engagement

- The service used a variety of means to engage with people who use the service and those close to them. This included surveys questions, and through social media.
- There was not a service award recognition scheme run by the provider.
- There were a number of opportunities for staff to be engaged in the service. This included staff ideas and feedback which was accessible via the intranet, monthly team surveys were conducted as part of the service's 'Open and Honest Programme'.
- Staff told us that they felt engaged with the service and were given the opportunity to voice their ideas and opinions were necessary.

Innovation, continuous improvement and sustainability

- The service demonstrated it was working hard to develop relationships with partner organisations and other stakeholders, to improve multidisciplinary team working and maternity care locally.

Maternity

- Whilst we have highlighted a number of concerns throughout this report, the provider has evidently made improvements in terms of governance since our last inspection in February 2016.
- We saw staff wanted to learn, develop and improve their skills; they were given protected time, resources and encouragement to do so.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure the safety of its staff by having a system in place to identify lone working staff's whereabouts during work time.
- The provider must ensure there is an up-to-date policy in place for medicines management, in relation to controlled drugs and medicines for the third stage of labour; and communicate this information to staff.
- The provider must ensure that accurate, complete and contemporaneous records are kept in relation to care and treatment. The records should clearly identify the pathway of risk for women. Also that postnatal records are accurately documented and easily assessable to other care providers.
- The provider must ensure that staff have regular one-to-one meetings with a line manager.
- The provider must ensure that local management and supervision arrangements are reviewed.

Action the provider SHOULD take to improve

- The provider should undertake a risk assessment for the transportation of Entonox and ensure that midwives are transporting Entonox in line with national safety recommendations.
- The provider should complete a risk assessment in relation to staff entering closed and empty buildings, and update their policies and procedures accordingly.
- The provider should ensure that all staff complete their annual mandatory training.
- The provider should ensure there are systems in place to monitor cleanliness and hygiene.
- The provider should keep their risk register fully up-to-date, including review of static risks and include a named lead for each risk.
- The provider should implement a Maternal Early Obstetric Warning Scoring (MEOWS) system.
- The provider should complete a needs assessment of the local community it provides a service to.
- The provider should make sure that all patient information leaflets have review dates on them.
- The provider should review the culture of midwives working at the Essex location.
- The provider should ensure that all staff are trained in providing care for patients with complex obstetric and medical conditions.
- The provider should ensure that staff have knowledge of Fraser competence.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (2) (a), (b) and (c)** **Good Governance** • **The provider did not have sufficient arrangements in place to monitor cleanliness and hygiene.** • **There was no system in place to identify lone working staff's whereabouts during work time.** • Accurate, complete and contemporaneous records were not always maintained in relation to care and treatment. The title of the women's pathway, for example high risks, must be recorded on women's healthcare records with the lead professional clearly identifiable. Where people's care had deviated from evidence-based practice recommendations, that healthcare records reflect the reason.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (2) (a) Staffing** **The provider had not ensured that staff had regular one-to-one meetings with a line manager. There was a lack of monitoring and supervision and leadership of staff working at the service.**